



STATEMENT OF EVIDENCE

From DOT KIRBY

ALSO ENC : DOCS^{1, 2}

Witness Statement to Clostridium Difficile Inquiry

1. My name is Dot Kirby and from August 1986 to early January 2009, I was employed by BBC Northern Ireland, Ormeau Avenue, Belfast. From August 1994, I was BBC NI's health correspondent.
2. The C Diff inquiry has asked me to provide a written statement of "your perception of the adequacy of the relevant factual information you received from the Northern Trust in regard to the outbreak and any views you may have as an experienced journalist on how such information flow should take place."

SEQUENCE OF EVENTS

3. On 22/1/08, I was editing a piece for BBC Newsline's main evening news programme on a ministerial announcement, when the TV producer of the day came in and told me that UTV had just run a story saying ten people had died in Antrim hospital from C Diff. He was unsure of the time period over which these deaths were supposed to have taken place.
4. I knew the Northern Trust – which ran the hospital - had offered their Chief Executive earlier that afternoon for interview and that BBC Radio Ulster had intended to interview a trust representative on Evening Extra (a programme which runs from 5pm to 6.30pm).
5. When I came out of editing, I checked my e mails. There was none from the Trust alluding to any deaths. (I don't recall if there was a more general one). I looked at the records I kept on infectious diseases to see how significant ten deaths in one hospital would be.
6. I then used the BBC's internal recording system to listen to the Evening Extra interview. In it, the Trust representative (I believe it was the medical director) admitted there had been a "problem with deaths." No figures were given. I looked at UTV's web-site which did indeed report ten deaths.
7. I rang the Trust's Head of Communications and asked her how many people had died. She said 16. I told her UTV were saying ten. She responded that UTV had asked how many people had died so far in Antrim hospital. To which the correct answer was 10. I had asked how many people had died in the Trust.
8. Subsequent BBC coverage that evening reflected these 16 deaths.

THE FIGURES

9. As I recall, the only Trust press release which detailed the total number of deaths (as opposed to the number of additional deaths) was issued on 8/2/08 and gave figures up to the previous day. The BBC have already

- supplied this press release to the inquiry (Doc _____).
10. This press release arose because I had asked for the age profile of those who had died. When I got a list of the age profile of 25 people, I queried the total as the Trust – at that point – had only said 23 had died where C Diff was the main cause of death or a contributing factor. The Trust told me that two more people had died since I had asked the question – hence the total was now 25.
 11. From this point, I kept a tally of the total number of deaths associated with C Diff; the number of people affected by C Diff in Northern Trust hospitals and the number of these who were classed as “recovering.” I also kept track of the number of new cases each month. I began this tally on the bottom of a sheet of paper and, as the outbreak wore on and I needed more room, I copied the figures onto another larger sheet and added to this table each time the Trust released new figures. I will send these two rather amateurish-looking tallies to the inquiry. (Doc 1 _____).
 12. If you take the “age profile” press release as your starting point, calculating a total for the number of deaths linked to C Diff is relatively straightforward. The figure given for the number of additional deaths, in each succeeding press release from the Trust, should be added. I no longer have these original press releases but the BBC have supplied the dates of the key ones – and relevant quotes – to the inquiry. They are contained in the document headed “Deaths related to Clostridium Difficile in the Hospitals of the Northern Trust” and are contained in the “Press Releases from the Trust” sub-section on the first page (Doc _____).
 13. In trying to tot up the figures from the press releases, there are only two points where you might go astray. Firstly, during the week following this “age profile” press release, the Trust issued another saying a further four people had died. In fact, two of these four had already been included in the 25 deaths (the Trust rang to tell me this). Obviously two of the four “new” deaths should therefore be discounted.
 14. Secondly, at the end of February, the Trust said their deaths that month had totalled 13. But the following week (on 4/3/08) they said another person had died on the last day of February. They said this person should be included in February’s total (bringing it to 14) as they would not be included in the Trust’s total for March.
 15. By the time the Trust declared the outbreak to be over, the number of deaths released by their media office had reached a total of 54.
 16. On the morning of 8/02/08 following a second appearance on Radio Ulster’s The Nolan Show, Northern Ireland’s Chief Medical Officer (CMO) issued provisional and interim figures (from the NISRA and the GRO) detailing the number of deaths in all Northern Ireland hospitals, where C Diff was believed to be the underlying cause of death or where it was mentioned on the death certificate (presumably as a contributory factor).

17. I will supply the inquiry with what I have kept of these figures. (Doc). I have only kept pages three and four but these contain the relevant tables. The figures released by the CMO showed the totals for each Northern Ireland hospital during each quarter of 2007. Extracting the quarterly totals for the Northern Trust from these tables, gave figures of six, four, six and 16 respectively. In other words, according to the CMO, in the latter half of 2007, the Northern Trust had had 22 deaths associated with C Diff.
18. A week earlier, (on 1/2/08) the Trust's Chief Executive had kindly given me a grid of such deaths in each month at the Trust during 2007. The BBC have already supplied this grid to the inquiry (Doc).
19. The Trust's grid recorded the total number of deaths in the final six months of 2007 as 13. Yet, according to the figures from the CMO, there had actually been 22 deaths in this period – nine more than the Trust at that stage believed.
20. Subsequently, these nine deaths were added into the total the BBC used (although I always attributed the source the first time I used them in any report). In the end, this total reached 63. As stated in para15, figures released from the Trust totalled 54.
21. It is perhaps worth noting that, in a BBC interview on 14/2/08, the Trust Chief Executive was asked "So you're expecting the death toll of 36 to turn out to be more accurate than the Trust's total of 27?" She replied: "Yes, we are."

WHEN DID IT ALL BEGIN?

22. At a very early stage after the outbreak was declared, I had a conversation with the Trust's Chief Executive when she came into Broadcasting House to be interviewed one evening on Evening Extra. She said the Trust had not initially realised they had an outbreak.
23. Given the size of the Trust, the amount of patient "traffic" and the fact that the Trust's grid showed no deaths at all in the first half of 2007, this seemed to me to be reasonable. I could see how the Trust, when deaths were recorded in July and August 2007, might hope that their figures would soon return to zero.
24. I do not recall, with certainty, when the Chief Executive said they had realised they had a serious problem but I think she said it was around the middle of October. They did not declare an outbreak until January 2008.
25. The Trust's grid showed no deaths in the first half of 2007 and 13 deaths in the latter half. When the Trust declared an outbreak in January 2008, they gave the total number of deaths as 16. It seemed reasonable to assume that the Trust thought (with hindsight) that their outbreak had actually

begun in or around July 2007.

26. However, the release of the new figures from the CMO on 8/2/08 made the picture much less clear. Quarterly totals of six, four, six and 16 made it (at the very least) arguable that the outbreak had begun much later than mid-Summer.
27. I thought it crucial to establish when the outbreak had actually started (and therefore which deaths should be included and which discounted).
28. It would also have been a useful piece of information to have told the public when compiling stories to have been able to say "The outbreak has now been continuing for X months."
29. I asked the Trust. They gave me the date on which they had declared the outbreak in January. I said I knew when they declared it – what I wanted to know was when they thought it had begun. I told them that obviously at the point they declared an outbreak they would already have had it for some time. So, what, I asked, was the start date? They repeated the date on which they had declared it. We had more than one circuitous exchange. In the end, I am fairly sure I raised my question under the Freedom of Information Act. But I got no further.

COVERAGE

30. During the course of the inquiry, the BBC have been criticised for being "negative," "overly critical" and "unbalanced" in its coverage of the outbreak. There is no doubt that some of the BBC's coverage (in which I played a major part) was negative. Given the subject matter, it would be surprising if that was not the case. But I do not believe it was overly critical or unbalanced.
31. For instance, on 25/1/08, BBC radio, television and on-line gave huge coverage to a ministerial announcement that an extra £9 million was to be spent on hospital cleaning. This figure was repeated a number of time during subsequent coverage of the outbreak
32. On 8/2/08, the BBC ran a story quoting the minister as saying that the number of C Diff cases in local hospitals had actually dropped substantially (quoting figures which were still being collated but comparing the first half of 2007 with the first half of 2006).
33. The BBC also, in this period, reported on Trust Chief Executives (not just the Northern Trust's) when they were grilled about the problem of combating C Diff by the NI Assembly's Health Committee at Stormont and the BBC in Belfast ran at least one story about a rise in C Diff in hospitals in the Western Trust. BBC Radio Foyle ran far more.
34. Soon after the outbreak began, the Northern Trust facilitated the BBC in

Antrim hospital when a camera team put pink fluorescent hair gel on the hands of a viewer and then follow her through the hospital as she went to visit her sick husband.

35. She left her mark on the lift button, ward door, bed rail, her husband, bedside table, visitor's armchair, bed linen etc. It was a graphic illustration of how bugs can be brought into a hospital from outside – and how they can be easily spread.
36. During the outbreak, the problem of the over-use of broad spectrum antibiotics and the ineffectiveness of end-of-bed gels were highlighted often during BBC coverage.
37. And finally, on one occasion, using animated graphics, I did a studio piece on C Diff during the BBC's main tea-time television news. This had no editorial purpose beyond attempting to educate the public in the problem of C Diff – how it multiplied and caused symptoms etc. I was later told by one former health PR person that she had watched it with her elderly mother who had remarked afterwards that, for the first time, she felt she understood C Diff.

INFORMATION FLOW

38. The health service would claim to be open, transparent and accountable. Given the amount of time they had to prepare for the day when they declared an outbreak, their performance was abysmal.
39. On the Wednesday or Thursday of the previous week, I checked out a tip-off I had received which said there was an infection causing problems in Antrim hospital and that operations had had to be cancelled.
40. I put in a series of questions to the Trust – asking if they had a problem with an infection; if they had, then what it was; symptoms; how many patients and staff were affected; if any beds had been closed to new admissions and if any operations had been affected. All but the last were standard questions I would ask of any Trust if I had been told they had a problem with any infectious disease.
41. The Trust came back fairly quickly (I think later that same day) to say no operations had been cancelled or otherwise affected. Despite repeated chasing, they were unable to answer the other questions. I now believe it was not that they were unable to answer the questions: it was that they were unwilling to do so.
42. Unfortunately the afternoon they chose to release their information coincided with an important ministerial budget announcement.
43. And, as the Trust had given no guidance or hint when they offered their

chief executive for interview that what she was going to say involved the death of any patients, the minister's budget announcement was regarded as more important by the BBC's main evening TV news programme.

44. As I have earlier stated, the Trust went on radio that evening to talk about a "problem with deaths" and, on UTV, to say that ten people had died in Antrim hospital when, in fact, they knew 16 people had died across the Trust. These interviews misled the public.
45. And, of course, there will have been public confusion later that evening when the BBC began reporting that 16 people had died.
46. In addition, UTV editorial staff who happened to be part of the BBC's audience that night will have been similarly confused – as well as those journalists preparing morning newspapers.
47. If journalists are confused, the public tends to get confused coverage. This is in no-one's interest.
48. The Trust's actions that day resulted in the public being misled and confused. Both were unnecessary and unjustifiable.

THE FUTURE

49. For what it's worth, I suggest that in future.....
 - Important announcements in the public interest (where possible) should not clash
 - Guidance should be given to journalists of the "flavour" of an announcement so that an editorial assessment of its importance can be made (this is already usual practice in the health service in Northern Ireland but was not adhered to on this occasion)
 - At all times, within the limits of patient confidentiality, there should be full and frank disclosure of all relevant facts. This is especially true of facts which are not just of public interest but in the public interest. Certainly the public should be told of any outbreak of an infectious disease in any public place, as soon as is practicable, after the relevant authorities realise what is happening.
 - Questions from journalists should be answered in a straight-forward manner
 - In future outbreaks, each successive press release should always include the up-to-date total of the number of cases/ deaths or whatever. Something along the lines of "This brings the number of deaths linked to C Diff (or whatever) so far to XX."
50. Finally, I would like to thank the inquiry for the opportunity to give evidence and to thank anyone who has persevered this far.

I confirm that the above statement is true to the best of my knowledge and belief.

Signed  (Dot Kirby)

Date.....21/10/2010

of these as recovering.

describe

INO TALLIES DOC 1	Beit treated	# who	Unk'd death	Dept.
6/2. Presumably (est)	26 cases	(1 recovery)	25 on fri.	34 (in fri)
Weds-13/2	28.	13 recovery	27	36
As 9. 20/2	25.	7 recovery	+2 = 29	38
As 9. 27/2	19	7 recovery	+4 = 33	42
4/3.			+1 = 34	43
28/2	24	9 recovery	+1 = 34	43
7/4 (far mark)			+3 = 37	46
New cases Jan 46			+2 = 39	48

- Jan 46
- Feb 27
- Mar 40
- Apr 37

~~Ampl~~
~~recovery~~

36
27
13

Doc 1

	504 Self-Tagged	of which	Unk'd deaths (Trust)	Unk'd deaths (Rest)	New cases
6/2 Accountly Unk	26 cases	(11 recover)	25	34 (unk)	Jan: 46
13/2 Unk	28	13	27	36	Feb 27
As of 26/2	25	7 recover	29 ^{7 Jan} _{9 Feb}	38	March 40
27/2	19	7 -	44 = 33 ^{Jan 7} _{Feb 13}	42	April 37
4/3			1 on 28/2 + 34 ^{Jan 7} _{Feb 14}	43	May 24
28/2	24	9 recover	41 = 34	43	June 22
3/4 (for March)			43 = 37	46	July = 19
for April			42 = 39	48	Aug = 11
for May	25	7	43 = 42	51	
Q2 JUNE	20 20	13	42 = 44	53	
JULY	12	10	48 = 52	61	
AUG	11	8 recovering	42 = 54	63	

Trust
 Work network
 Not out.
 RGA said "continued in Feb!!"

1000

(WHO) procedures so as to facilitate international comparison on a standard basis. Deaths caused by "enterocolitis due to Clostridium difficile" infection, can be identified using the WHO International Classification of Diseases, Tenth Revision, code A.04.7. Additional work is then done looking at the ICD codes that are related to Clostridium difficile and searching the cause of death text field on the death certificate for mentions of Clostridium difficile, C.difficile or pseudomembranous colitis.

Codes used to identify deaths where Clostridium difficile was the underlying cause of death (on deaths where Clostridium difficile was mentioned) are A.04.7, A.09, A.41.4, A.49.8 and P.36.5.

Information has been produced for the first nine months of 2007. In the table below provisional figures for quarter 1 to 3 in the registration year 2007, by place of death are presented.

Deaths Registered Where Clostridium Difficile was mentioned on the Death Certificate, by Place of Death, Q1-Q3 2007 whether as underlying cause or otherwise mentioned on the death certificate, provisional data

Place of Death	Quarter			Total for NT
	1	2	3	
Altnagelvin Area Hospital	0	2	0	
Antrim Area Hospital	2	3	4	9
Belfast City Hospital	2	2	0	
Braid Valley Hospital	2	0	1	3
Causeway Hospital	1	0	0	1
Craigavon Area Hospital	2	1	1	
Daisy Hill Hospital	0	1	0	
Erne Hospital	0	1	0	
Lagan Valley Hospital	0	0	1	
Mater Infirmorum Hospital	1	0	0	
Mid-Ulster Hospital	1	0	0	1
Robinson Memorial Hospital	0	1	0	1
Royal Victoria Hospital	1	0	3	
Ulster Hospital	3	3	4	
Whiteabbey Hospital	0	0	1	1
	6	4	6	16

N'cy Trk

All Other Places	0	1	2
Total	15	15	17

In GRO a special exercise has been undertaken which entails detailed checking of death registrations for references to Clostridium Difficile and producing figures for the most recent quarter which can be used as a check on hospital data. Such GRO figures are interim as they have not have gone through the full checking process. The information is noted below.

Deaths Registered Where Clostridium Difficile was mentioned on the Death Certificate, by Place of Death, Q4 2007 whether as underlying cause or otherwise mentioned on the death certificate, interim data

Place of Death	Quarter	
	4	
Altnagelvin Area Hospital	1	
Antrim Area Hospital	9	9
Belfast City Hospital	4	
Causeway Hospital	1	1
Craigavon Area Hospital	2	
Robinson Memorial Hospital	1	1
Royal Victoria Hospital	1	
Ulster Hospital	3	
Whiteabbey Hospital	5	5
All Other Places	3	
Total	30	

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